Nicola Low, Rob Miller, and Helen Ward

TREAT THE SYMPTOMS AS WELL AS THE CAUSE

HIV related symptoms, for example nausea, anorexia, or pain, may occur at any stage of HIV disease. They may be due to HIV itself, to the use of highly active antiretroviral therapy (HAART), to comorbidity, such as liver disease from hepatitis C, or to HIV associated malignancy such as non-Hodgkin lymphoma. Harding *et al* (***see p 5***) performed a systematic review to identify the effects of different models of palliative care on patient outcomes. They found that home palliative care and inpatient hospice models of care improved outcomes (pain, symptom control, anxiety, insight, and spiritual wellbeing). The authors suggest that palliative care should be offered as an integral part of HIV clinical care throughout the course of a patient's HIV disease. However, they also point to the weakness of the evidence base for this recommendation; studies on the benefits of palliative care are often limited by poor experimental methods and few standardised outcome measures. The accompanying editorial by Selwyn (***see p 2***) highlights the continued need for palliative care for patients living with HIV infection, not just for end of life care, but also for active management of symptoms caused by treatment—such as HAART.

See p 2 and 7

ONCE MORE ON CHLAMYDIA SCREENING

Chlamydia screening appears again as a theme in this issue, reflecting intense current international interest in the subject. One paper from the Netherlands clearly shows the feasibility of using home collected urine samples for chlamydia screening (***see p 17***). The 41% response was high for a study of this kind and chlamydia prevalence was much higher in urban than rural areas. The Dutch researchers also found that a score including demographic and behavioural factors could identify 79% of chlamydia cases by screening only 33% of the population (***see p 24***). This raises the intriguing possibility of a population based programme combining universal postal screening in urban areas and selective screening in rural areas. A study of practice nurses in Wales (***see p 31***) reminds us that, in the UK, we have a long educational and cultural journey ahead of us before chlamydia screening of men and partner notification are taken up in primary care widely enough to give opportunistic chlamydia screening any chance of success.

See p 17, 24, and 31

SELF TESTING IMPROVES UPTAKE

Access to health services can be difficult for people who inject drugs, yet they may have a high rate of undiagnosed and untreated infection. An innovative outreach project for drug users in Melbourne looked at the impact of testing method on the uptake of screening (***see p 53***). The outreach workers compared genital screening rates from a pilot study, when swabs were to be taken by a healthcare worker, and in an intervention phase where participants were offered the option of a self collected specimen. They found much higher uptake with the latter method. Participants were also offered the option of taking their own blood, supervised by the healthcare worker. Overall 74% were found to have hepatitis C infection; genital infections were far less common, but high enough to warrant screening.

See p 53

BUT IT'S REALLY URGENT...

In the UK there is intense pressure at the moment to cut waiting times for sexual health services, but most clinics cannot cope with the demand by offering everyone an appointment within 2 days. Many clinics have introduced triage systems to try and manage demand more effectively. Handy and Pattmen (***see p 59***) review results of a structured triage system based on a scoring system. This has the advantage of providing a more objective measure of need, always provided that there is good communication between the patient and the person carrying out the triage. Their paper highlights real problems for any triage system; while most people with severe symptoms were seen quickly, they noted that only 86% of people with untreated chlamydia and only 54% of men with testicular pain were seen within 48 hours. Once again the answer seems to be more resources—modernisation and efficiency drives can only go so far in improving sexual health services.

See p 59

LGV MORE COMMON THAN WE THOUGHT?

There have been a number of reports of outbreaks of lymphogranuloma venereum (LGV) among men who have sex with men in Europe, including a number of men with HIV infection. Meyer and colleagues (***see p 91***) report three cases of LGV in men in Hamburg. They typed the organism and found that they were all *Chlamydia trachomatis* serovar L2, but interestingly none reported sexual contact outside of Germany within the past 12 months, and a sequence based typing system suggested strains from three different sources. The authors argue that infection with *C trachomatis* L2 is more common than previously thought.

See p 91